Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

# PA/ADTA

## PRIOR AUTHORIZATION
## AODA DAY TREATMENT ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

### RECIPIENT INFORMATION

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Recipient | Im | A | 1234567890 | 32 |
| LAST NAME | FIRST NAME | MIDDLE INITIAL | MEDICAL ASSISTANCE ID NUMBER | AGE |

### PROVIDER INFORMATION

| 6 | 7 | 8 |
|---|---|---|
| I.M. Provider | 87654321 | ( XXX ) XXX - XXXX |
| REQUESTING/PERFORMING PROVIDER'S NAME AND CREDENTIALS | REQUESTING/PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER | REQUESTING/PERFORMING PROVIDER'S TELEPHONE NUMBER |

| 9 | 10 |
|---|---|
| I.M. Referring | 12345678 |
| REFERRING/PRESCRIBING PROVIDER'S NAME | REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER |

### A. LENGTH AND INTENSITY OF TREATMENT REQUESTED

- Program request is for 4 hours per day
  4 days per week
  for 4 weeks
  for a total of 64 hours.
- Anticipated beginning treatment date 3/20/89
- Estimated AODA Day Treatment discharge date 4/14/89
- Attach a copy of treatment design, which includes the following:
  a) Schedule of treatment (day, time of day, length of session and service to be provided during that time) (PROGRAM SCHEDULE ATTACHED)
  b) Brief description of aftercare/continuing care/follow-up component (also include this information in treatment plan section below.) Each recipient will be referred to at least 12 weeks of group therapy consisting of one 90-minute group per week.

### B. DIAGNOSIS

- Dates of diagnostic evaluations or medical examinations:
  3/15/89--clinical interview and assessment
  3/17/89--psychiatric team staffing
  3/18/89--medical exam
- Specific diagnostic procedures which were employed:
  Clinical intake tool used at our agency
  MAST
  MMPI

- Recipient's current primary and secondary diagnosis codes (DSM-III-R) and descriptions:
  Primary-303.90(Alcohol dependence), as manifested by loss of control, periods of attempted abstinence, morning agitation and tremor, continued use of alcohol in spite of ulcer and high blood pressure, increased tolerance, and inability to secure employment.

  Secondary-305.20 (Cannabis abuse), as manifested by periodic use despite social problems associated with use, pattern of use over past four years.

## C. HISTORY

- Describe the recipient's **current** clinical problems and relevant clinical history, including AODA history.
  Recipient presents at our clinic with suicidal ideation, difficulty sleeping, negative self-abuse references, recently separated from spouse because of drinking incident.
  Recipient reports drinking 3 to 5 times per week, consuming 6 to 15 beers per occasion. Reports history of loss of control, blackouts, OWI's, and loss of job associated with use. In addition, recipient is continuing to drink despite ulcer and high blood pressure. History of periods of abstinence over past 10 years. Recipient also reports weekly to monthly use of "pot." Denies other substance use.
  Recipient seems motivated for treatment and has agreed to abstinence from all psychoactive substances.
  In addition, recipient claims positive history of family alcoholism for at least 2 generations. Recipient has no children and currently lives with friend while in separation period.

- Has the recipient received **any** AODA treatment in the past twelve months?
  _X_ YES ____ NO

- If YES, provide information on date of each treatment episode, type of service provided, and treatment outcomes.
  About one year ago, recipient was arrested for OMVWI and had weekly outpatient counseling as a condition to continued driving privileges. Recipient reports he was not able to abstain during that period and fabricated his use history.

- If the recipient received any inpatient AODA care, intensive outpatient AODA services or AODA Day Treatment in the past twelve months, please give rationale for appropriateness and medical necessity of current request. Please discuss projected outcome of additional treatment requested.

  Not applicable

## D. SEVERITY OF ILLNESS

- Describe the recipient's severity of illness using the following indicators.
  Please refer to the AODA Day Treatment criteria.

1. Loss of control/relapse crisis: As reported, recipient is very likely to continue use without close monitoring. Also, recipient has only been able to abstain for 7 to 10 days without structure. Abstinence will be monitored as well as withdrawal possibilities.

2. Physical conditions or complications: Though recipient has ulcer and high blood pressure, our M.D., after evaluation, feels that he is stable enough to benefit from program. Our nurse on staff will monitor withdrawal symptoms.

3. Psychiatric conditions or complications: Recipient has signs of depression. However, it is felt these are more a consequence of the substance abuse and not its cause. In any event, underlying depression will be evaluated.

4. Recovery environment: Current instability of the recipient's living environment will be greatly remedied by day treatment. (Spouse has agreed to attend family education component and receive supportive outpatient therapy).

5. Life areas impairment: Recipient's use history indicates impairments in relationships with spouse, OWI's, and financial and vocational difficulties.

6. Treatment acceptance/resistance: Recipient is willing to become involved with treatment. This is demonstrated by his commitment to abstain, attend all sessions, and participate in counseling with spouse.

## E. TREATMENT PLAN

- Attach a copy of the recipient's AODA Day Treatment plan (please refer to intensity of service guideline in the AODA Day Treatment criteria).
  (CLINICAL TREATMENT PLAN USED IN RECIPIENT'S CASE FILE ATTACHED)
- Describe any special needs of the recipient and indicate how these will be addressed (for example, educational needs, access to treatment facility).
  Recipient will be brought to clinic on first day of treatment by spouse. After that, he will be introduced to our "volunteer drivers" program and he will be responsible to ask for ride shares.

- Describe the recipient's family situation. Indicate how family issues will be addressed in treatment, if applicable. If family members are not involved in treatment, explain why not. Recipient has been married 10 years, no children. He on occasion has been verbally abusive to spouse. Spouse has attempted to "shelter" him from consequences of his own drinking. She has agreed to attend all lectures open to family members. She also has agreed to be seen by a psychotherapist to deal with her co-dependency issues and own depression. She is motivated for couples work when recipient is more stable.

- Briefly describe treatment goals and objectives.

1. Recipient agreed to abstain from pot and alcohol use.
2. Recipient will prepare own AODA history by end of the first week.
3. Recipient will verbalize history to group by end of the second week.
4. Recipient will begin to understand centrality of alcohol in family of origin and in own life.
5. Recipient will begin to identify and express feelings by the end of 4th week.
6. Recipient will show beginning emotional grieving needed in recovery.
7. Recipient will attend at least 2 AA/week.

- Please describe the expected outcomes of treatment including the plan for continuing care.

1. Recipient will have cycle of addiction interrupted.
2. Will agree to 12 weeks of aftercare.
3. Will begin to develop self-support system, including sponsor for 6 - 12 months after treatment.
4. Will understand concepts of shame, victimization, and emotional grief as issues of the recovery.
5. Will develop self-reflective skills.
6. Will understand the addictive disease process.

COUNTY RECOMMENDATION (OPTIONAL) If the County Human Services Department or 51.42 Board has made a recommendation on this request, documentation may be attached. THIS INFORMATION IS OPTIONAL.

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## F. RECIPIENT AUTHORIZATION

I have read the attached request for prior authorization of AODA Day Treatment services and agree that it will be sent to the Medical Assistance Program for review.

Im A. Recipient
Signature of recipient or representative (if representative, state relationship)

Relationship to recipient

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**G.** Attach a photocopy of the physician's current prescription for AODA Day Treatment. (Must be dated within one month of receipt at EDS).

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**THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NONPAYMENT OF THE BILLING CLAIM(S).**

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**H.** P. M. Performing
Signature of Performing Provider

M.S.
Discipline of Performing Provider

I.M. Supervising, M.D.
Name of Supervising Physician or Psychologist

87654321
Provider Number of Supervising Provider

P. M. Supervising
Signature of Supervising Physician or Psychologist

MM/DD/YY
Date